Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151590	A. BUILDING _____ B. WING _____	C 02/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASERACARE HOSPICE	**3775 HALEY DR STE B NEWBURGH, IN 47630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was a state hospice complaint investigation. Complaint #: IN00102495 - Unsubstantiated: Lack of sufficient evidence. Facility #: 004386 Survey Date: 2-20-12 Medicaid Vendor #: 200519300 Surveyor: Vicki Harmon, RN, PHNS Total hospice census: 45. 34 skilled nursing facility residents. Aseracare Hospice was found to be in compliance with IC 16-25-3-4 version b which by reference includes 42 CFR 418.20 Eligibility requirements, 418.22 Certification of terminal illness, 418.24 Election of hospice care, 418.25 Admission to hospice care, and 418.26 Discharge from hospice care as were related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN February 22, 2012	S 000		